DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING		LETED	
			B. WIN			07/22/2	011
NAME OF B	AD OUT DED ON GUIDNI HED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>	
NAME OF P	PROVIDER OR SUPPLIER			17650 (	GENERATIONS DRIVE		
WOOD R	RIDGE ASSISTED LI	IVING		SOUTH	I BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
R0000							
	This visit was for	a State Residential	R	0000	The preparation and execution		
	Licensure Survey	<i>7</i> .			this plan of correction does not constitute an admission or		
	This visit include	ed the Investigation of			agreement by Wood Ridge		
	Complaint IN000	93337			Assisted Living of the facts		
					alleged or the conclusion set		
	Complaint IN00	093337			in this statement of deficienc		
	•	ate Residential findings			Correction and specific corre	ctive	
		egation are cited at:			actions are prepared and/or executed in compliance with state		
	R0154 and R 0273				rules.		
	10134 and 10273						
	Survey dates: July 20, 21 and 22, 2011						
	,	,					
	Facility number:	001148					
	Provider number:	: 001148					
	AIM number: N	/A					
	Survey Team:						
	Sandra Haws, RN	N TC					
	Toni Krakowski,						
	Vicki Manuwal, l						
	· ·						
	Bobbi Costigan, I	IXIV					
	Census Bed Type	<b>.</b> •					
	Residential: 56	••					
	Total: 56						
	Census by payor	tyne.					
	Other: 56	7) P.C.					
	Total: 56						
	10181. 30						
	Residential samp	le· 7					
	Supplemental sar						
	Supplemental sar	πρισ. 10					
LABORATOR'	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

2RKP11

Facility ID:

001148

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUIL	DING	STRUCTION 00	(X3) DATE S COMPL <b>07/22/2</b>	ETED
WOOD F	PROVIDER OR SUPPLIER	IVING	B. WING	STREET AI 17650 G SOUTH	DDRESS, CITY, STATE, ZIP CODE ENERATIONS DRIVE BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
R0144	in accordance wi Quality review c 2011 by Bev Fau  (a) The facility sha state of good repa	ompleted on July 27,					
	residents. Based on intervioration facility failed to a was clean and in chapel having 7 a seats and a rough hole in the wall the large cooling unity and allowing the room. The facility floor was free frost to ensure 3 resides soiled toilets (Re 27) and 2 resider #39) did not have	ews and observations, the ensure the environment good repair related to the chairs with soiled stained a finish, a large gaping that once contained a texposing the outside outside heat to enter the y failed to ensure the 2nd om urine odors and failed ent rooms did not have sidents: # 50, #2, and # ats (Resident #50 and e wastebaskets with urine for 4 of 4 residents in a mple of 10.	R0	144	Replacement chairs for the chapel have been ordered. The conditioning unit had been removed on 7/21/11 in order the maintenance supervisor to clean and repair it. A covering the hole in the wall was proving After the unit was cleaned and repaired, it was placed back the space it occupied, after the space was cleaned. The soile attends were removed. The seats and bathrooms were cleaned. Housekeeping and C.N.A. assignment sheets and updated to include checking resident apartments each shiftensure trash, including incontinent briefs, is emptied toilets and bathrooms are cleared. When a resident is initially assessed by Health Services Supervisor or designousekeeping	for to ng for ided. nd in nat ed toilet e all iff to and eaned	08/22/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
			B. WIN			07/22/2011	
		<u> </u>	F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		17650 (	GENERATIONS DRIVE		
	RIDGE ASSISTED L	IVING	_	SOUTH	I BEND, IN46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	SS-REFERENCED TO THE APPROPRIATE	
TAG	1	LSC IDENTIFYING INFORMATION)	-	TAG		:11	DATE
	1	the 2nd floor on 7/20/11			abilities/incontinence issues was be reviewed to determine who		
	1	companied by QMA # 3,			or not the resident requires	Cuici	
	_	ne odor was present.			housekeeping services each	shift,	
	Upon entrance in	nto Resident #39's room,			daily, every other day, or we		
	a very strong uri	ne odor was present in the			This will be re-assessed duri	•	
	room. The strong	g odor was detected prior			quarterly service plan review when there is a change in	s or	
	to entering the re	oom. The resident's			condition.The Maintenance		
	wastebasket was	observed to be full of			Supervisor, Administrator, He	ealth	
	urine soaked bri	efs. The odor on the 2nd			Services Supervisor or desig	nee	
	floor continued on 7/20/11 at 12:00 p.m., 1:00 p.m., 2:00 p.m., 3:00 p.m. and 4:00				will monitor daily during roun		
					a continuous basis to ensure		
	1 -	urine odor was present on			apartments are clean. Our cr is that rounds are made by the		
	1 -	7/21/11 at 9:00 a.m.,			designees on a daily basis to		
		1:00 a.m., 12:00 p.m.			ensure compliance.		
		o.m. 3:00 p.m. 4:00 p.m.					
		On 7/22/11, a strong urine					
	_	t on the 2nd floor at 8:30					
	1						
	1	10:00 a.m., 11:00 a.m.					
	1 .	p.m., 2:00 p.m. and 3:00					
	p.m.						
	"	the facility's 2nd floor,on					
	7/21/11 at 11:00	a.m., an observation was					
	made of the faci	lity's chapel area. The					
	chapel contained	l 7 wooden straight back					
	_	seats. The finish on the					
	wood was worn	off exposing bare wood					
	1	ne chairs. The cloth seats					
		r with dark soiled stains					
		An observation at that					
		of a large opening in the					
		ontained a cooling unit.					
	1	l a metal vent which					
	anowed the not	outside air to enter the					

l	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED  COMPLETED				
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING		07/22/2011		
			B. WING	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER			GENERATIONS DRIVE			
WOOD F	RIDGE ASSISTED L	IVING	l l	BEND, IN46635			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
		oor. According WSBT, a					
		ert channel on 7/21/11 at					
	_	utside temperature was					
		egrees with a heat index					
	_	ees. The large opening					
		have a ledge on the					
		straw pieces, dirt debris					
		yish colored droppings					
		e chapel had a strong					
	smell of cigarette smoke. A bottle of						
	Fabreez (deodorizer) was observed being removed by the Director of Nursing.						
	1	iew with the Director of					
	Nursing on 7/21/						
	1	apel, she indicated the air					
	1	t was removed to use in a					
		She further indicated the					
	facility is a non-s						
	facility is a non-s	smoking facility.					
	During an intervi	iew with Resident #50,					
	who was observe	ed to be wheelchair					
	bound, on 7/21/1	1 at 11: 30 a.m., she was					
	concerned about	the facility					
	housekeeping. Tl	he resident went into her					
		inted to her wastebasket.					
	The wastebasket	was full of urine soaked					
		top of the 18 inch deep					
		briefs were stacked 12					
		op. The resident indicated					
	1 -	are stacked past the sink					
		eping may come in only					
		mpty the trash. A					
		observed next to the					
	resident's bed. So	oiled briefs were					

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STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO				COMPLETED	
			B. WIN			07/22/2	011	
			-		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEI	· ·		17650 (	GENERATIONS DRIVE			
	RIDGE ASSISTED L	LIVING			I BEND, IN46635			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION	
TAG	<b>+</b>		+	TAG	DEFICIENC!)		DATE	
		he wastebasket half full.						
		ilet was observed to have						
		eared on the toilet lid. The						
	_	was soiled with paper						
	and dirt debris.	Γhe bathroom floor tile						
	was observed to	be discolored with dirt. A						
	dry soiled wash	cloth was observed on the						
	floor next to the	toilet. The resident's						
	room was locate	d on the 2nd floor.						
	During a tour of the facility on 7/21/11 at							
	3:20 p.m., accompanied by Maintenance							
	1 1	ervation was made of						
		throom. The resident's						
		yed to be soiled with dark						
		treaks all along the inside						
	1	1. A tour of Resident						
		/21/11 at 3:30 p.m., an						
		made of his toilet bowl						
		streaks all around the						
	inside of the toil	et bowl.						
	During an interv	riew with the Maintenance						
	1	ling the strong urine odors						
	1 -	on 7/21/11 at 3:30 p.m.,						
	he had no comm	_						
	During an interv	riew with the						
	Administrator on 7/21/11 at 6:00 p.m.							
		sident's wastebasket						
	1	h urine soaked depends						
	1	iled toilets, and urine						
		floor, she indicated the						
	nousekeeping st	aff clean only once						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/22/2011
	PROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP CODE GENERATIONS DRIVE H BEND, IN46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
R0148	(e) The facility sha grounds, and equi in good repair, and adversely affect the residents or the put (1) Each facility sha written program the continued upker (2) The electrical sappliances, cords, sources, fire alarm shall be maintaine functioning and concelectrical codes. (3) All plumbing shall be in Based on interview facility failed to eventilating systems where the continued upker (4) At least yearly, systems shall be in Based on interview facility failed to eventilating systems.	all establish and implement for maintenance to ensure seep of the facility. System, including switches, alternate power and detection systems, d to guarantee safe mpliance with state stall function properly and plumbing codes. The heating and ventilating inspected. Sew and observation, the ensure their heating and im was inspected at least cient practice has the tall 56 of 56 residents ity.	R0148	The heating and ventilation systems have been inspected. The air conditionin the second floor had been working properly until the ext heat conditions which occurr on 7/20/11. The company th services the air conditioning this community was contacted.	creme ed at for ed on
	During a tour of at 11:15 accompa	the 2nd floor on 7/20/11 anied by QMA # 3, the ature felt very warm. The		7/20/2011 regarding the warr conditions in the building. The company arrived on 7/21/20° The service technician inspethe unit, cleaned it, filled with freon and at the end of the day.	ne 11. cted

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
			B. WIN			07/22/2	011
		<u> </u>	F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R		17650 (	GENERATIONS DRIVE		
	RIDGE ASSISTED L	LIVING	_	SOUTH	BEND, IN46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
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TAG	-	·	+	TAG			DATE
		the wall was observed to			was working adequately. A no conditioning unit was installe		
	_	QMA # 3 agreed it was			8/2/2011. The service techn		
		remained warm all day.			inspected the ventilating sys		
		er on the 2nd floor at 2:25			on 8/2/2011.The preventive		
	p.m. was observ	ed to read 84 degrees.			maintenance form for record	ing	
					air conditioning and heating inspections includes an area	for	
	During an interv	riew with the Maintenance			yearly inspection of the heati		
	staff # 2 on 7/20	0/11 at 12:10 p.m.			and ventilating system.The	5	
	regarding the wa	arm temperature on the			Maintenance Supervisor is		
	2nd floor, he indicated some of the residents like their windows or balcony				responsible to monitor the		
					checklist monthly to ensure prompt inspection of the syst	tomo	
	doors open. During the tour of multiple				The Maintenance Supervisor		
	1 ^	on the 2nd floor on			review the form with the		
		rs or windows were			Administrator monthly.		
	observed to be o						
	observed to be o	pen.					
	During another t	tour of the 2nd floor on					
	7/21/11 at 9:00 a	a.m. and throughout the					
	day, the 2nd floo	or temperature felt very					
	1 -	rvation was made of the					
	thermostat at 9:0	00 a.m., reading 70					
		nperature outside on					
	"	degrees according to					
	WSBT, a local v	C					
	1	entire day the thermostat					
	_	rees even though the					
		he 2nd floor felt much					
	_	e day at 3:00 p.m. During					
		h the Maintenance staff #					
		) p.m., regarding the					
	1	ng at 70 degrees all day					
	_	temperature of the floor					
		indicated he wasn't sure					
	why it wasn't wo	orking properly.	1				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. NYNG  (X3) DATE SURVEY  COMPLETED  07/22/2011			ETED		
			B. WING			07/22/20	711
NAME OF I	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE ERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING	so	UTH BEN	ND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	CR	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
R0154	regarding the wa 2nd floor and if the system had been The Administrate and ventilation sychecked.  (k) The facility shad areas, common districted in with 410 IAC 7-24. Based on observative record review, the kitchen area and well maintain practice had the process of the system of the system. Findings include the process of the system of	If keep all kitchens, kitchen ining areas, equipment, and e from litter and rubbish, good repair in accordance ation, interview, and e facility failed to ensure and equipment was clean ned. This deficient potential to affect 56 of ate and resided in the	R0154	at cle dis kit ar Di 8/ in ite ar Af ur pr	I areas noted to be in need tention have been addresse eaning, saniftizing and/or scarding and removing from tchen. Color coded "day do the utilized for monitoring open discard dates. The Registictician will present an inser 9/11 to review sanitation cluding proper storage of forms, serving items and uter and labeling and dating items for the inservice, staff will inderstand and demonstrate toper safety and sanitation andards. Cleaning schedule are been revised to include	ed by  In the obs"  In the obs's ten obs's tered ovice  In the obs's tered ovice obs's ten obs's	08/22/2011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S	ETED
			B. WIN			07/22/2	UII
NAME OF	PROVIDER OR SUPPLIER	t		1	DDRESS, CITY, STATE, ZIP CODE SENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING		SOUTH	BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	The kitchen hand with a build-up of large stove (right black, charred but was not in operation convection oven compartment sin with a greasy grater of black fuzzy substance, pots and two large baked-on dark brater of black food (prep) preparent of the sprint preparent of the sprint preparent of the compartment white, scaly matter that sink had large cove molding and brown/gray loose above the three of sink had condens observed dripping glasses, a large, to opening in the center of the commercial of the commerci	dwashing sink was laden of white scaly matter, the thoosen was laden with aild-up (left side oven ting order), two cream ols (one under the and one under the two k) were heavily laden ay/black soil, dime sized rowth, the fan and coil frigeration unit) and a the walk-in cooler were d-up of a white or black the outer finish of two ge frying pans had a rown/black charred ered ceiling vent over the aration area lacked a kler-head over the food iden with a build-up of vent in the dishwashing posits on it, the kitchen's at sink had a build-up of ter, the floor vent beneath ge rust deposits and the did floor had a build-up of edirt, a ceiling vent compartment dishwashing station which was ag onto a rack of clean rectangular, uncovered eiling, immediately over dishwasher unit, had an build-up of black, furry,			more detailed checklist to en all areas of sanitation are covered. Dining Services Manwill attend a Serve Safe Trait The Dining Services Manager review cleaning schedules of daily basis to ensure they are being followed. The Dining Services Manager will review cleaning schedules at least weekly with the Administrato ensure compliance and follow through. The Dining Services Manager, cooks, Administratoral are responsible to monitor to ensure compliance.	nager ning er will n a e v the r to w	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION  00	COM	TE SURVEY MPLETED	
			B. WING		07/22 _	2/2011
	PROVIDER OR SUPPLIER		1765	ET ADDRESS, CITY, STATE, ZIP 50 GENERATIONS DRIV JTH BEND, IN46635		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	CROSS-REFERENCED TO TH	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	)	DATE
		o the interior walls of the				
	shaft, the floor a	· ·				
	*	eath the dishwasher unit				
		build-up, the white pipe				
	_	arbage disposal had a				
		stance clinging to the				
	pipe, the ice mac					
		ime on its circumference,				
		or grout was black				
	1	of the kitchen, the cove				
	· -	or underneath and behind				
		ven and stove was				
		eavy build-up of dark				
		, a large, beachball sized				
		l baseball sized craters				
		t of the walk-in cooler				
	concrete floor.					
		cility cleaning schedule				
		dicated the sinks, and				
		be cleaned daily. The				
		ns were to be cleaned				
	bi-weekly. The i	ce machine and coolers				
		ed weekly and checked				
		ls. All major appliances				
		under weekly. The July				
		ed all of the above had				
	been completed	through July 20, 1011.				
	"	iew with the Dietary				
	~	7/11 at 11:20 A.M., he				
	indicated he had	only been employed at				
	the facility for fi	ve weeks. He further				
	indicated the kite	chen was in need of a				

Facility ID:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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			B. WING		07/22/2011
	ROVIDER OR SUPPLIER		1765	ET ADDRESS, CITY, STATE, ZIP CODE O GENERATIONS DRIVE	
WOOD R	IDGE ASSISTED L		SOU	TH BEND, IN46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	two cream-colore for or why they v preparation area.				
R0179	(c) Each facility sh conditioning syste applicable rules of building safety cor conditioning syste normal operating onecessary to provitemperatures in al Based on intervie facility failed to temperature for r 2nd floor of the firesidents in a supand had the poter residents that live	I resident and public areas.  ews and observations, the maintain a comfortable esidents living on the	R0179	Until the extreme heat conditated occurred on 7/20/11 the conditioning unit on the seconditioning unit on the seconditioning for this facility we contacted on 7/20/2011 regard the warm conditions in the second floor hallways. The company technician arrived	air and he ir vas arding
	Findings include	:		7/21/11 to service the unit. The technician inspected the unit cleaned the fan, filled the unit freon and it was working	.,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	iG		07/22/2	011
NAME OF	PROVIDER OR SUPPLIEI	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					GENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING		SOUTH	I BEND, IN46635		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	the 2nd floor on 7/20/11			adequately at the end of the service call. A new unit was		
	1	companied by QMA # 3,			installed on 8/2/2011. The		
		nperature felt very warm.			second floor temperature rer	nains	
	The thermomete	er on the wall was			at a comfortable level.All air		
	observed to read	80 degrees. QMA # 3			conditioning units in all		
	agreed it was wa	arm. The floor remained			apartments have been worki	-	
	warm all day. Th	he thermometer on the			properly, and were in workin order on the days the hallwa		
	2nd floor at 2:25	p.m., was observed to			were extremely warm.Reside		
	read 84 degrees.				and staff members are awar		
					report any air conditioning ur	nit	
					that may not be working properly. The Maintenance		
	During an interv	riew with the Maintenance			Supervisor checks apartmen	ts	
	1	0/11 at 12:10 p.m.			and hallways daily to ensure		
	1	arm temperature on the			units are in good working		
	1 -	licated some of the			order.Administrator conducts		
	•	eir windows or balcony			daily rounds and will monitor		
	1	ing tour of multiple			temperatures in the hallways apartments. The Maintenance		
	1 ^	on the 2nd floor 7/20/11,			Supervisor will meet at least		
		dows were observed open.			weekly to discuss any proble		
	no doors or wind	dows were observed open.			or concerns with the		
	Daning on attend				Administrator.		
	1 -	tour of the 2nd floor on					
		a.m. and throughout the					
	1 *	loor daily, the 2nd floor					
	temperature felt						
	1	made of the thermostat at					
	1	ng 70 degrees. The					
	_	side on 7/21/11 was 97					
	1 ~	ng to WSBT, a local					
	weather station.	Throughout the entire day					
	1	tayed at 70 degrees even					
	though the temperature of the 2nd floor						
	felt much hotter	later in the day at 3:00					
	p.m. During an	interview with the					
	1 -	ff # 2 on 7/21/at 3:50 p.m.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN	G		07/22/2	011
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE	-	
W000 5	ND 05 40010TED 1	n 411.0			GENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING		SOUTH	I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG			_	TAG	DEFICIENCY)		DATE
		rmostat staying at 70					
	degrees all day e	· ·					
	1 -	ne floor felt warmer, he					
		n't sure why it wasn't					
	working properly	<i>i</i> .					
		00 p.m., the 1st floor					
		much cooler. The					
	thermostat on the	e 1st floor wall was					
	observed to read	70, same as reading the					
	2nd floor althoug	gh the 2nd floor felt much					
	warmer. The disc	crepancy was brought to					
	the Maintenance	staff # 2's attention with					
	no comment other	er than he indicated the					
	2nds floor therm	ostat may not be working					
	properly.						
	During an intervi	iew with Resident #35					
	1	ne 2nd floor on 7/21/11 at					
	3:10 p.m. regardi	ing the temperature of the					
		ed it was very warm on					
		needed to go into her					
		The sitting area where					
		elevision was very warm,					
		ed running and blowing					
	warm air towards						
		o man direction.					
	During an intervi	iew with Resident #45 on					
	_	.m., who was observed					
	_	vision area and resides on					
	_	e stated "It's way too					
		-					
	warm up nere, it	s not comfortable at all."					
	During an intervi	iew with Resident #36					

001148

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  O7/22/2011					
			B. WING			07/22/20	011
	PROVIDER OR SUPPLIER			17650 GE	ENERATIONS DRIVE		
	RIDGE ASSISTED L		;	SOUTHE	BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	(X5) COMPLETION DATE
D0241	who resides on the 2nd floor, on 7/21/11 4:45 p.m. regarding the temperature on the 2nd floor, she indicated it was very warm. Resident #36's requested her room air conditioner be observed. The air conditioner was observed to be at the highest cooling and fan selection. The room did not feel cold with the air conditioner set at the highest speed and coldest selection. Resident # 36 indicated she gets very hot at night and then feels cold in the morning. A wall thermostat in the resident's room was not observed.						
R0241	provision of reside as ordered by the shall be supervised premises or on cal (1) Medication shallicensed nursing predication aides. Based on interviet facility failed to given according to regarding correct coverage for 3 of 16, 23, 46) review coverage and fail	ntial nursing care shall be resident ' s physician and d by a licensed nurse on the	R024	41	The physician's orders for residents #16, #23, #46, and have been reviewed, clarified if necessary corrected to indiproper sliding scale and othe tests/procedures required.Ott residents who had the potent be affected were identified through a facility audit.The consultant pharmacist will	l and cate r her	08/15/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 07/22/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 17650 GENERATIONS DRIVE WOOD RIDGE ASSISTED LIVING SOUTH BEND, IN46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (Resident #7, 16) reviewed with conduct an inservice on 8/15/11 to review diabetic care including medications and failed to follow blood accu checks, sliding scales and pressure parameters for 1 of 6 residents insulin administration. The Health (Resident # 16) reviewed for hypertension Services Supervisor or designee will review diabetic records daily and failed to follow call orders for 1 of 3 to ensure proper procedures for residents (Resident # 23) reviewed for call diabetic residents are orders and failed to ensure Accu Checks followed. The Health Services (finger stick blood sugar test) were done Supervisor or designee will review as ordered for 3 of 3 residents (Resident # medication administration records daily to ensure physician orders 16, 23, 46) reviewed with Accu Checks in for medications have been a sample of 7. followed. This will be done on a continuous basis. The Health Findings include: Services Supervisor or designee will notify physicians daily, if need, regarding residents who's blood 1. The clinical record for Resident # 46 sugars are not within sliding scale reviewed on 7/20/11 at 11:00 A.M., guidelines, and who's blood indicated diagnoses of, but not limited: pressures are not within noted parameters. The Health Services diabetes mellitus, hypertension, and Supervisor, Medical Records hyperthyroidism. Designee, Administrator are responsible to monitor to ensure The July 2011, "Physician's Orders", compliance. indicated, "...Accu Checks before meals and at HS (bedtime)...5/4/11...Novolin R...sliding scale...200-250=4 units: 251-300=6 units; 301-350=8 units; 351-420=10 units...5/4/11..." Review of the May 2011, "Medication Record", indicated Accu Checks were only done at 7:30 A.M. and HS. It further indicated incorrect sliding scale coverage for the following: 5/7/11 HS Accu Check - 279 given 5

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			07/22/2	011
			D. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIER				GENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING			I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	<b>.</b>	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	units. The next available Accu Check was						
	197 on 5/8/11 at	7:30 A.M.					
	Review of the Ju	ne 2011, "Medication					
	Record", indicate	ed Accu Checks were					
	· ·	A.M. and HS. It further					
	1 *	ct sliding scale coverage					
		Accu Check testing for					
		Accu Check testing for					
	the following:						
		Check - 221 given 6					
	units. The next a	available Accu Check was					
	85 on 6/7/11 at 7	:30 A.M.					
	6/22/11 Accu Ch	eck at HS not completed.					
		•					
	Review of the Ju	ly 1st through July 19th,					
		on Record", indicated					
	· ·	re only done at 7:30					
		•					
		further indicated					
	·	scale coverage for the					
	following:						
	7/16/11 HS Accu	Check - 232 given 0					
	units. The next a	available Accu Check was					
	98 on 7/17/11 at	7:30 A.M.					
	70 OH 7/17/11 at 7.50 A.W.						
	A "Physician's Telephone Orders", dated						
	5/4/11, indicated, "Accu Check A.C.						
	(before meals)'						
		nsultation Report", dated					
	5/1/11 through 5/	/31/11, signed by the					
	physician on 6/6/	/11, indicated,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
			A. BUIL B. WING			07/22/2	011
NAME OF	PROVIDER OR SUPPLIE	R	-!		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WOOD F	RIDGE ASSISTED L	IVING			GENERATIONS DRIVE BEND, IN46635		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	DEND, IN-10000		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	"Recommend BS (blood sugar) QID						
	1 `	y) ac & hs x (times) 7 days					
	1	ost-prandial (after eating)					
		O (twice daily) rotating					
		and dinner with before					
	1	hysician's ResponsesI nmendation(s) above"					
	accept the recon	imenuation(s) above					
	Review of a (Na	me) lab report, dated					
	`	l, "Hgb A1C (blood test					
	1	average of blood sugars					
	for the prior thre	ee months)13.1 (H)					
	(high)Normal	4.2-5.8; Good Control					
	5.5-6.8; Fair Co	ntrol 6.9-7.6; Poor					
	Control > (great	er than) 7.6"					
	An "Initial Eval	uation/Service Plan for					
		e", dated 1/18/11, updated					
	4/19/11 & 7/19/	_					
		.Requires staff to order,					
	store and dispen	se					
	medication(s)I	Extended Service.					
	1 ^	check CBG's (blood					
	sugars) more that	nn daily"					
	The clinical reco	ord lacked documentation					
		condition and how she					
	felt after receiving the incorrect insulin						
	coverage.	-					
	D start to t	7/01/11 -4 0 55 D.M.					
	1 -	v on 7/21/11 at 2:55 P.M.,					
		ed the doctor didn't totally					
	1	y times he really wanted they are just doing it					
	Accu Checks 80	are just doing it					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUI	LDING	00	07/22/2	
			B. WIN		A PARTICIO CUTA CTATE TIA CORE	0112212	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE GENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING			BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	further indicated she was					
		nt # 46 had a more					
	current Hgb A1C	Cresult.					
	2 The climical m	ecord for Resident # 16					
		0/11 at 3:55 P.M.,					
		ses of, but not limited:					
		, hypertension, and atrial					
	fibrillation.	, hypertension, and atrial					
	mornium.						
	The July 2011, "I	Physician's Orders",					
	indicated, "Dig	•					
	(micrograms)g	ive 1 tablet orally every					
	other day on odd	daysVerapamil ER 240					
	mg (milligrams).	give 1 tablet orally once					
	a day - Hold for	SBP (systolic blood					
	pressure) < (less	than) 130Accu Checks					
	dailyNovolin R	2sliding					
	scale151-200=2	2 units; 201-250=4 units;					
	·	s > (greater than) 350=10					
	units & call MD.						
	Daview - £41- A	amil 2011 "Madiantian					
	1	oril 2011, "Medication ed incorrect sliding scale					
	coverage or lack						
	monitoring for th						
	inomitoring for th	ic following.					
	4/5/11 Accu Che	ck - 192					
	4/9/11 Accu Che	ck not done					
	4/10/11 Accu Ch	eck not done					
	4/15/11 Accu Ch	eck - 160					
	4/19/11 Accu Ch	eck - 167					
	4/20/11 Accu Ch	eck - 151					
	4/22/11 Accu Ch	eck - 210					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CC	NSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUII	LDING	00	COMPL 07/22/2	
			B. WIN			0112212	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE GENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING			BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	$\neg$	ID	DROUBERG DE AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR		TAG	DEFICIENCY)	DATE		
	4/23/11 Accu Ch						
	4/25/11 Accu Ch						
	4/26/11 Accu Ch						
	4/27/11 Accu Ch						
	4/28/11 Accu Ch						
	4/29/11 Accu Ch						
	4/30/11 Accu Ch	eck - 177					
	The clinical recor	rd lacked documentation					
	of sliding scale c	overage for 11 days in					
	April when cover	rage was indicated.					
	The April 2011, '	'Medication Record",					
	lacked document	ation of blood pressure					
	monitoring for 25	5 of 30 days.					
	Review of the M	ay 2011, "Medication					
		ed incorrect sliding scale					
	coverage for the	•					
	5/2/11 Accu Che						
	5/4/11 Accu Che						
	5/6/11 Accu Che						
	5/12/11 Accu Ch						
	5/16/11 Accu Ch						
	5/17/11 Accu Ch						
	5/18/11 Accu Ch						
	5/22/11 Accu Ch						
	5/24/11 Accu Ch						
	5/28/11 Accu Ch	eck - 167					
	The clinical reco	rd lacked documentation					
	of sliding scale c	overage for 10 days in					
	May when cover	age was indicated.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN			07/22/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WOOD E	DIDGE ASSISTED I	IVING			GENERATIONS DRIVE I BEND, IN46635		
	RIDGE ASSISTED L				I DEND, IN40033		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CONTROL OF THE APPROPRIED CONTR		TΕ	COMPLETION DATE
IAG	REGULATORT OR	LSC IDENTIFFING INFORMATION)		IAU			DATE
	The Mey 2011 "	Medication Record",					
		ration of blood pressure					
		6 of 30 days and further					
	1	owing 3 blood pressure					
		•					
	but Verapamil wa	below the parameters					
	i out verapanin wa	as sum given.					
	5/7/11 - 112/86						
	5/14/11 - 112/80						
	5/21/11 - 118/84						
	3/21/11 - 110/04						
	Review of the In-	ne 2011, "Medication					
		ed incorrect sliding scale					
	coverage for the	_					
	coverage for the	ionowing.					
	6/10/11 Accu Ch	eck - 153					
	6/11/11 Accu Ch	eck - 189					
	6/23/11 Accu Ch	eck - 183					
	6/28/11 Accu Ch	eck - 200					
	6/30/11 Accu Ch	eck - 178					
	The clinical reco	rd lacked documentation					
	of sliding scale c	overage for 5 days in					
	June when covers	age was indicated.					
	The June 2011, "	Medication Record",					
	lacked documentation of blood pressure						
	monitoring for 26 of 30 days and further indicated the following 2 blood pressure						
	readings that fell	below the parameters					
	but Verapamil wa	_					
	_						
	6/4/11 - 106/87						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUI	LDING	00	COMPL	
			B. WIN			07/22/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WOOD 5	NDOE ACCIOTED I	IV/INIO		1	GENERATIONS DRIVE		
	RIDGE ASSISTED L			SOUTH	I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG			-	TAG			DATE
	6/11/11 - 128/86						
	D : 0.1 I	2011 112 6 12					
		ne 2011, "Medication					
	· ·	ked documentation of					
		ceiving her scheduled					
	` `	tion used to regulate					
	heart rates) on 6/	5/11 and 6/19/11.					
		1 2011 112 5 11 11					
		ly 2011, "Medication					
	· ·	ed incorrect sliding scale					
	coverage for the	following:					
	7/6/11 Accu Che						
	7/13/11 Accu Ch	eck - 191					
		rd lacked documentation					
		overage for 2 days from					
		July 20th when coverage					
	was indicated.						
		ugh July 20th, 2011,					
	"Medication Rec	ord", lacked					
	documentation of	f blood pressure					
	monitoring for 1'	7 of 20 days and further					
	indicated the foll	owing 2 blood pressure					
	readings that fell	below the parameters					
	but Verapamil wa	as still given:					
	7/9/11 - 100/50						
	7/16/11 - 120/62						
	Review of an "In	itial Evaluation/Service					
	Plan for Resident	tial Care", dated 3/30/11,					
	updated 6/29/11,						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE SU COMPLE			
			A. BUILDI B. WING	ING		07/22/20		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  17650 GENERATIONS DRIVE  SOUTH BEND, IN46635					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	(X5) COMPLETION DATE	
	"Medications store and dispens medication(s)R	Requires staff to order,						
	A (Name) lab report, dated 3/26/10, indicated, "Digoxin 1.0range 0.9-2.0"							
	During interview on 7/21/11 at 2:50 P.M., LPN # 1 indicated Resident #16 refuses sliding scale coverage and it should be charted on the MAR (Medication Administration Record). She further indicated the facility typically faxes the doctor at the end of the month to inform him/her of the refusal however the clinical record lacked documentation.							
	On 7/22/11 at 10:05 A.M., LPN # 1 indicated the doctor ordered blood pressure and pulses weekly and also ordered daily blood pressures so unsure what the order should be.							
	indicated the faci from the doctor a blood pressure m	ld Verapamil for systolic						
	~	with LPN # 1 on .M., she indicated						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUIL		00	07/22/2	
			B. WINC		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				SENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING			BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	] 1	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAU		last Digoxin level for		IAG			DATE
		he further indicated the					
		e stated the resident was					
	_ :	e levels drawn twice a					
	year.	o lovely drawn twice a					
	, , , , , , , , , , , , , , , , , , , ,						
	3. The clinical r	record for Resident # 23					
		/11 at 10:55 A.M.,					
		ses of, but not limited to:					
		, hypertension, and					
	hypothyroidism.	, , , ,					
	The July 2011, "I	Physician's Orders",					
	indicated, "Acc	cu Checks 4 X					
	dailyNovolog	sliding scale before					
	meals and at bed	time141-160=1 units					
	(sic); 161-180=2	units; 181-200=3 units;					
	201-220=4 units;	; 221-240=5 units;					
	241-260=6 units;	; 261-280=7 units;					
	281-300=8 units:	; 301-320=9 units;					
	321-340=10 unit	s; 341-360=11 units;					
		s; 381-400=13 units;					
		s; 421-440=15 units;					
		s; 461-480=17 units;					
		s; < (less than) 100 or >					
	(greater than) 50	0 call MD"					
	Review of the A	oril 2011, "Medication					
	1	ed incorrect sliding scale					
	coverage or lack	_					
	monitoring for th						
	4/1/11 4:30 P.M.	- 182 given 2 units					
		me) - 143 given 0 units					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	E CON	OO	COMPL	ETED	
			B. WING			07/22/2	011
NAME OF I	PROVIDER OR SUPPLIER		1		DDRESS, CITY, STATE, ZIP CODE ENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING	so	UTH I	BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	_	DEFICIENCY)		DATE
	4/10/11 4:30 P.M 142 given 0 units						
	,	time) - 143 given 0 units					
		M no Accu Check done					
		1 262 given 6 units					
	4/26/11 11:30 A.	M 199 given 2 units					
	The clinical reco	rd indicated a total of 7					
	incorrect sliding	scale coverages during					
	the month of Ap						
	1						
	The April 2011,	"Medication Record"					
	further indicated	the following Accu					
	Check results that	at fell within call					
	parameters:						
	•						
	4/3/11 7:00 A.M	92					
	4/4/11 7:00 A.M	98					
	4/5/11 7:00 A.M	93					
	4/5/11 11:30 A.N	Л 92					
	4/5/11 4:30 P.M.	- 90					
	4/14/11 7:00 A.N	Л 79					
	4/19/11 4:30 P.M	1 97					
	4/28/11 4:30 P.M	177					
	4/30/11 7:00 A.N	Л 98					
	_	h of April 2011, the					
		cked documentation of					
	physician notific	ation of low blood sugars					
	a total of 9 times						
	Davian of the M	av 2011 "Medication					
		ay 2011, "Medication					
	·	ed incorrect sliding scale					
	coverage or lack						
	monitoring for th	ne following:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	NSTRUCTION 00	(X3) DATE: COMPL 07/22/2	ETED	
			B. WIN		DDBEGG CITY GTATE ZID CODE	0112212	011
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE SENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING			BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
IAG	5/1/11 HS - 141 5/3/11 HS - 192 5/6/11 HS - 170 5/9/11 11:30 A.M 5/11/11 11:30 A.M Next available B 5/15/11 4:30 P.M documented 5/15/11 HS - 199 5/24/11 4:30 P.M 5/28/11 11:30 A.M The clinical reco incorrect sliding lack of Accu Che 2 times during th The May 2011, " further indicated Check results that parameters:  5/1/11 11:30 A.M 5/8/11 7:00 A.M 5/13/11 7:00 A.M 5/13/11 7:00 A.M 5/14/11 4:30 P.M 5/15/11 7:00 A.M 5/16/11 7:00 A.M 5/16/11 7:00 A.M 5/18/11 7:00 A.M 5/20/11 7:00 A.M 5/20/11 7:00 A.M	given 0 units given 4 units given 3 units M 211 given 6 units M 128 given 8 units. S reading 149. M 227 no coverage D given 2 units M 150 given 2 units M no Accu Check done ord indicated a total of 7 scale coverages and a eck monitoring a total of the month of May 2011.  Medication Record" the following Accu the following Accu the following Accu at fell within call  M 76 99 M 90 M 96 M 94 M 97 M 97 M 97 M 97 M 97 M 96 M 94 M 94		IAG	DISTRIBUTE 1		DATE
	5/23/11 7:00 A.N	И 98					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN			07/22/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WOOD	DIDGE ASSISTED I	IV/INIC		1	GENERATIONS DRIVE		
	RIDGE ASSISTED L	IVING		SOUTH	I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		,	+	IAG	DEFICIENCE (		DATE
	5/24/11 7:00 A.N						
	5/27/11 7:00 A.N						
	5/29/11 7:00 A.N 5/30/11 7:00 A.N						
	3/30/11 /.00 A.N	1 83					
	Dumin a tha mant	a of Mary 2011 tha					
	~	h of May 2011, the cked documentation of					
	a total of 15 time	ation of low blood sugars					
		S.					
	Review of the June 2011, "Medication						
		ed incorrect sliding scale					
	coverage or lack	•					
	monitoring for th						
		ie following.					
	6/1/11 4·30 P M	- 162 no coverage					
	documented	- 102 no coverage					
		no coverage documented					
		1 188 given 2 units					
	6/8/11 HS - 189	_					
	6/13/11 HS - 182	_					
		I 166 no coverage					
	documented	1. 100 110 00 voi ugo					
		M no Accu Check done					
		Accu Check done					
	0,27,11110-1101	1000 CHOOK WOIL					
	The clinical reco	rd indicated a total of 6					
		scale coverages and a					
		eck monitoring a total of					
		e month of June 2011.					
	2 miles during th	2 month of June 2011.					
	   The June 2011 "	Medication Record"					
	· ·	the following Accu					
	Check results that	_					
		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPI	
			B. WING	G		07/22/2	2011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					SENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING		SOUTH	BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	parameters:						
	6/1/11 7:00 A.M						
	6/2/11 7:00 A.M						
	6/4/11 7:00 A.M	90					
	6/7/11 7:00 A.M	85					
	6/8/11 7:00 A.M	98					
	6/12/11 7:00 A.N	И 99					
	6/13/11 7:00 A.N	И 92					
	6/13/11 4:30 P.M	1 79					
	6/14/11 4:30 P.N	1 80					
	6/17/11 7:00 A.M 92						
	6/17/11 4:30 P.M	1 96					
	6/22/11 7:00 A.N	Л 97					
	6/24/11 4:30 P.M						
	6/27/11 7:00 A.N						
	6/28/11 7:00 A.N						
	0/20/11 /.00 /1.1	11. 00					
	During the mont	h of June 2011, the					
		cked documentation of					
		ation of low blood sugars					
	a total of 15 time	_					
	Review of the In	ly 2011, "Medication					
		ed incorrect sliding scale					
	coverage for the	_					
	coverage for the	ionowing.					
	7/2/11 HS - 172	given 3 units					
		1 239 given 0 units					
		•					
	7/16/11 HS - 170	given 3 units					
	TT111						
		rd indicated a total of 3					
	1	scale coverages from					
	July 1st through	July 20th, 2011.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN			07/22/2	U11 
NAME OF F	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
					GENERATIONS DRIVE		
WOOD R	RIDGE ASSISTED L	IVING		SOUTH	I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	CROSS-REFERENCED TO THE AP		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	The July 2011, "I						
	further indicated the following Accu Check results that fell within call						
	parameters:						
	7/3/11 4:30 P.M.	- 82					
	7/5/11 4:30 P.M.	- 90					
	7/7/11 4:30 P.M.	- 80					
	7/16/11 4:30 P.M	I 91					
	//10/11 4.30 F.IVI 91						
	During the month	n of July 2011, the					
	_	cked documentation of					
		ation of low blood sugars					
		_					
		from July 1st through					
	July 20th, 2011.						
	D : C 111	:::1E 1 :: /G ::					
		itial Evaluation/Service					
		tial Care", dated 3/29/11,					
	updated 6/28/11,	·					
		Requires staff to order,					
	store and dispens						
	medication(s)E	xtended Service:					
	Requires staff to	check CBG's more than					
	daily"						
	Review of a (Nat	ne) Lab report, dated					
	3/19/11, indicated, "Hemoglobin A1Cnormal range 4.0 -						
	6.03/18/116.2						
	Interview with L	PN # 1 on 7/21/11 at 2:55					
		ed she is unsure if the					
		orders were followed or					
	Uloou sugai call	orders were followed of					l l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY  COMPLETED  07/22/2011		
			B. WING			07/22/2	U11 
	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ENERATIONS DRIVE		
WOOD R	RIDGE ASSISTED L	IVING	SO	JTH	BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	TAG	$\dashv$	DEFICIENCI)		DATE
		sician when the blood					
	_	an 100. She further					
		rse draws up the insulin					
		ose is not checked by a					
		confirm accuracy of the ndicated it is not a facility					
	policy to check the	•					
		Records at the end of the					
		g scale dosing accuracy.					
	monum for sname	scare dosing accuracy.					
	The Lippincott M	Manual of Nursing					
	The Lippincott Manual of Nursing Practice, Fourth Edition, indicated,						
	· ·	ng Glucose (blood sugar)					
		g/dlnormal post					
		ugar 2 hours after meals)					
	-	The dose of insulin is					
	_	tain the blood glucose					
		ge (65-130 mg/dl)When					
	_	ents are changing rapidly,					
	-	ections of regular insulin					
	are given before	each mealNURSING					
	ALERT: There i	s a narrow margin					
	between the amo	unt of insulin needed to					
	make the blood g	glucose normal and the					
	amount that will	cause hypoglycemia"					
	The 2010 Nursin	g Spectrum Drug					
		ated, "digoxindrug					
	-	peutic index, so dosage					
		ed regularly and patient					
	must be monitore						
		icityTell patient to take					
	drug at same time						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	IG		07/22/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
					GENERATIONS DRIVE		
WOOD R	RIDGE ASSISTED L	IVING		SOUTH	I BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	titled, "Communication					
	with Physicians"						
	"It is the policy of this facility to keep						
	the residents' physicians informed						
	regarding the res	idents' conditionThe					
	Community will						
	documentation of	f notification of the					
	physician(s) of a	change in resident					
	condition in the r	resident record"					
	Review of a facil	lity policy titled,					
	"Guidelines for I	Delegation", undated,					
	indicated, "Thr	ough the assessment					
	process, the RN	will be able to determine					
	_	neters, for the action to					
		son(s) to be notified, that					
	1	unique to each resident. "					
	op 11111						
	4 Review of Re	esident # 7's clinical					
		1 at 12:45 p.m., indicated					
		not limited to, senile					
	_	I mental status, and HTN					
	(hypertension).	i ilicitar status, and 1111					
	(Hypertelision).						
	During a record	review of the "Physician's					
	~	01/11 through 4/30/11,					
	· ·	nlafaxine HCL ER					
		g (milligram) (used for					
		n once daily by mouth					
		l on 4/7/11. A new order					
		HCL ER 75 mg to be					
	1	by mouth was started on					
	4/7/11.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED				
			A. BUILDING B. WING	00	07/22/2011			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  17650 GENERATIONS DRIVE  SOUTH BEND, IN46635					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  During a record review of the "Medication Record" dated 4/8/11, QMA #3 charted that Venlafaxine HCL ER 37.5 mg was given. And again on 4/8/11 LPN #4 charted that Venlafaxine HCL ER 75 mg. Total dose given on 4/8/11 was Venlafaxine HCL ER 112.5 mg.  During an interview with LPN #1 on 7/20/11 at 3:00 p.m., she indicated that she was unaware the Venlafaxine HCL ER was given twice on 4/8/11. LPN # 1 indicated that the nurse must have "accidentally" signed the Medication Record twice.		ID PREFIX (EACH CORRECTIVE ACTION SHOULD) TAG  PROVIDER'S PLAN OF CORRECTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE			
R0247	shall be noted in the physician shall be medication administrated or potential resident.  Based on intervious the facility failed physicians updat medication administration administration document those of record for 4 of 7	edication administration ne resident 's record. The notified of any error in stration when there are any detrimental effects to the  ew and record review, to keep the residents' ed regarding errors in nistration and failed to errors in the clinical residents reviewed for s in a sample of 7.	R0247	The physicians for residents #6, #23, and #46 have been notified regarding the sliding scales and insulin administra as well as other medication on the potential to be affected widentified through a facility at their records. An inservice regarding medication errors	ation errors ad vill be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
			B. WIN			07/22/2	011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .		17650 (	GENERATIONS DRIVE		
	RIDGE ASSISTED L			SOUTH	BEND, IN46635		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident # 7, 16, 23, 46,  Findings include:  1. The clinical record for Resident # 46 reviewed on 7/20/11 at 11:00 A.M., indicated diagnoses of, but not limited: diabetes mellitus, hypertension, and hyperthyroidism.				report and recording and physician notification will be h 8/15/2011. The Medication E Policy and Procedure and Medication Error form will be	Error	
					reviewed. Nurses and Q.M./ will understand what constitu- medication error and how to complete the form. The inse will also review the state rule these findings so that they increase their understanding reporting medication errors.T	ervice and	
	The July 2011, "Physician's Orders", indicated, "Accu Checks before meals and at HS (bedtime)5/4/11Novolin Rsliding scale200-250=4 units; 251-300=6 units; 301-350=8 units; 351-420=10 units5/4/11"  Review of the May 2011, "Medication Record", indicated incorrect sliding scale coverage on:  5/7/11 at HS - Accu Check 279. Given 5 units but should have received 6 units.			de M R m er w pr tw	Health Services Supervisor of designee will review the Medication Administration Records daily to ensure proposed medication administration, and errors are noted, that the forwas completed properly and physician was notified. At least twice weekly, the Health Services and administration of the services and the services are services and the services and the services are services and the services are services and the services are services as a service and the services are services and the services are services as a service and the services are services and the services are services as a service and the se	per nd if m the st vices	
					Supervisor or designee will not the finings with the Administration This will be completed on an on-going basis and become of the routine quality assurant.	ator. part	
					review.The Health Services Supervisor, Medical Records Designee and Administrator responsible to monitor to ens	are	
	The June 2011, "	'Medication Record",			compliance.		
		ect sliding scale coverage					
	on:						
	6/6/11 at HS - Accu Check 221. Given 6						
	units but should have received 4 units.						
		aly 1st through July 19th, on Record", indicated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL 07/22/2	
			B. WIN			0112212	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE GENERATIONS DRIVE		
WOOD R	RIDGE ASSISTED LI	IVING			BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	incorrect sliding	scale coverage on:					
		Accu Check 232. Given 0 nave received 4 units.					
	The clinical record of physician notic						
	2. The clinical reviewed on 7/20 indicated diagnost diabetes mellitus. fibrillation.						
	indicated, "Dig (micrograms)gi other day on odd mg (milligrams). a day - Hold for S pressure) < (less dailyNovolin R scale151-200=2	daysVerapamil ER 240give 1 tablet orally once SBP (systolic blood than) 130Accu Checkssliding 2 units; 201-250=4 units; > (greater than) 350=10					
	Record", indicate	oril 2011, "Medication ed lack of sliding scale following 11 days when licated:					
	4/5/11 Accu Checreceived 2 units. 4/9/11 Accu Chec	ck - 192. Should have					

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CON	NSTRUCTION	C	X3) DATE S	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00		COMPLI	
		B. WIN				07/22/20	)   T	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE			
WOOD 5	NDOE ACCIOTED I	N/INIO			ENERATIONS DI	RIVE		
WOODF	RIDGE ASSISTED L	IVING		SOUTH	BEND, IN46635			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		N OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED DEFICIE	TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICI	ENC I)	-	DATE
	4/10/11 Accu Check not done							
	4/15/11 Accu Check - 160. Should have							
	received 2 units.							
		neck - 167. Should have						
	received 2 units.							
		neck - 151. Should have						
	received 2 units.							
		neck - 210. Should have						
	received 4 units.							
	4/23/11 Accu Ch							
		neck - 163. Should have						
	received 2 units.							
		neck - 216. Should have						
	received 4 units.							
	4/27/11 Accu Ch	neck - 193. Should have						
	received 2 units.							
	4/28/11 Accu Ch	neck - 178. Should have						
	received 2 units.							
	4/29/11 Accu Ch	neck - 184. Should have						
	received 2 units.							
	4/30/11 Accu Ch	neck - 177. Should have						
	received 2 units.							
	The May 2011, "	'Medication Record",						
	indicated lack of	sliding scale coverage						
	for the following	10 days when coverage						
	was indicated:							
	5/2/11 Accu Che	eck - 154. Should have						
	received 2 units.							
	5/4/11 Accu Che	eck - 187. Should have						
	received 2 units.							
	5/6/11 Accu Che	eck - 170. Should have						
	received 2 units.							
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/22/2011	
	PROVIDER OR SUPPLIER		17650 (	ADDRESS, CITY, STATE, ZIP CODE GENERATIONS DRIVE I BEND, IN46635	0772272011
				. 52.15,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
IAU	<del>                                     </del>	·	IAG	DET CHERCET,	DATE
		eck - 160. Should have			
	received 2 units.	1 172 Cl 111			
		eck - 152. Should have			
	received 2 units.				
		eck - 181. Should have			
	received 2 units.	1 165 01 111			
		eck - 165. Should have			
	received 2 units.	1 170 01 111			
		eck - 170. Should have			
	received 2 units.	1 165 01 111			
		eck - 165. Should have			
	received 2 units.	1 167 01 111			
		eck - 167. Should have			
	received 2 units.				
	The May 2011 "	Medication Record",			
	1	Verapamil was given on			
		lays when Resident # 16's			
		eadings fell below the			
	hold parameters:	<del>-</del>			
	noid parameters.				
	5/7/11 - 112/86				
	5/14/11 - 128/82				
	5/14/11 - 126/82				
	3/21/11 - 110/04				
	Review of the Ju	ne 2011, "Medication			
		ed lack of sliding scale			
	· ·	following 5 days when			
	coverage was inc	-			
	<i>J</i>				
	6/10/11 Accu Ch	eck - 153. Should have			
	received 2 units.				
	6/11/11 Accu Ch	eck - 189. Should have			
	received 2 units.				

NAME OF PROVIDER OR SUPPLIER  WOOD RIDGE ASSISTED LIVING  NAME OF PROVIDER OR SUPPLIER  WOOD RIDGE ASSISTED LIVING  SUNTH BEND. IN466935  SUTH BEND. IN46693	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IA (X2) N	MULTIPLE CO	NSTRUCTION	(X	(3) DATE S COMPLE		
STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DRIVE SOUTH BEND, IN46635  Oct ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MIST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MIST BE PERCEDED BY FULL (EACH DEFICIENCY MIST BE PERCED BY FULL (EACH DEFICIENCY	AND FLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00			
WOOD RIDGE ASSISTED LIVING  CAPID PRETIX TAG  (FACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC (IDENTIFYING INFORMATION)  (6/23/11 Accu Check - 183. Should have received 2 units.  (6/30/11 Accu Check - 178. Should have received 2 units.  The June 2011, "Medication Record", further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled  Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when the following two days when the following two days when the load parameters and also lacked documentation of Resident # 16 receiving her scheduled  Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was				B. WI		DDDECC CITY CTAT			
CAST   DEMMARY STATEMENT OF DEPICIENCES   DEPICEMENT OF DEPICIENCES   CAST   DEPICIENCES   CAST   DEPICEMENT OF DEPICIENCES   CAST   DEPICEMENT OF DEPICIENCES   CAST   DEPICEMENT OF DEPICIENCES   CAST   DEPICEMENT OF REGILATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   CAST   DEPICEMENT OF THE APPROPRIATE   CAST   DATE	NAME OF P	ROVIDER OR SUPPLIER	1		1				
PREFIX TAG REGULATORY OR LIGHTIFYING INFORMATION)  6/23/11 Accu Check - 183. Should have received 2 units. 6/28/11 Accu Check - 200. Should have received 2 units. 6/28/11 Accu Check - 178. Should have received 2 units. 6/30/11 Accu Check - 178. Should have received 2 units. 6/30/11 Accu Check - 178. Should have received 2 units.  The June 2011, "Medication Record", further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was	WOOD R	IDGE ASSISTED L	IVING				TTTV L		
### TAG REGULATORY OR LSC IDENTIFYING INFORMATION)    6/23/11 Accu Check - 183. Should have received 2 units.     6/28/11 Accu Check - 200. Should have received 2 units.     6/30/11 Accu Check - 178. Should have received 2 units.     6/30/11 Accu Check - 178. Should have received 2 units.     The June 2011, "Medication Record",     further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled     Digoxin (medication used to regulate heart rates) on the following 2 days:    Verapamil     6/4/11 - 106/87     6/11/11 - 128/86     Digoxin     6/5/11     6/19/11     Review of the July 1st through 20th,     2011, "Medication Record", indicated     lack of sliding scale coverage for the     following two days when coverage was				1	ı				
6/23/11 Accu Check - 183. Should have received 2 units. 6/28/11 Accu Check - 200. Should have received 2 units. 6/30/11 Accu Check - 178. Should have received 2 units.  The June 2011, "Medication Record", further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil 6/4/11 - 106/87 6/11/11 - 128/86  Digoxin 6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		*				CROSS-REFERENCED	TO THE APPROPRIATE		
received 2 units. 6/28/11 Accu Check - 200. Should have received 2 units. 6/30/11 Accu Check - 178. Should have received 2 units.  The June 2011, "Medication Record", further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was	IAG				IAG	DEFE	in in it is a second of the interest of the in		DATE
6/28/11 Accu Check - 200. Should have received 2 units. 6/30/11 Accu Check - 178. Should have received 2 units.  The June 2011, "Medication Record", further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was									
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6/30/11 Accu Check - 178. Should have received 2 units.  The June 2011, "Medication Record", further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was									
received 2 units.  The June 2011, "Medication Record", further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was				'A					
The June 2011, "Medication Record", further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was									
further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		received 2 units.							
further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		The June 2011	'Medication Record"						
the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		*		n					
pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was									
parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		•	•						
of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		-		ion					
Digoxin (medication used to regulate heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was				<b>I</b>					
heart rates) on the following 2 days:  Verapamil  6/4/11 - 106/87  6/11/11 - 128/86  Digoxin  6/5/11  6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was			-						
Verapamil  6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		•	•						
6/4/11 - 106/87 6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		11001111000) 011 011							
6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		Verapamil							
6/11/11 - 128/86  Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		6/4/11 106/97							
Digoxin  6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was									
6/5/11 6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		0/11/11 - 120/00							
6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		Digoxin							
6/19/11  Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		6/5/11							
2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was									
2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was		Davious of the I-	ly let through 20th						
lack of sliding scale coverage for the following two days when coverage was			•						
following two days when coverage was			•						
		•	•						
IIIulcalcu.		•	iys when coverage was						
		murcated.							
7/6/11 Accu Check - 204. Should have		7/6/11 Accu Che	ck - 204 Should have						
received 4 units.			CK - 207. BHOUIU HAVE						
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2RKP11 Facility ID: 001148 If continuation sheet Page 36 of 57	FORM CMS 2		ans Obsalata Eva	nt ID: ODIZD44	1 Facility I	D: 004440	If continuation char	at Da =	o 26 of F7

2RKP11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN			07/22/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WOOD F	NDCE ACCIOTED I	IV/INIO			GENERATIONS DRIVE		
	RIDGE ASSISTED L			SOUTH	BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
		eck - 191. Should have					
	received 2 units.						
	Th. I 1 1 4 41	1. 20/1. 2011					
	The July 1st thro						
		ord", further indicated					
		iven on the following 2					
	l -	ood pressure readings fell					
	below the hold p	arameters:					
	7/0/11 100/50						
	7/9/11 - 100/50						
	7/16/11 - 120/62						
	The climical reco	nd looked doormantation					
		rd lacked documentation					
	of physician noti	fication.					
	During intervious	on 7/21/11 at 2:50 P.M.,					
	~	ed Resident # 16 refuses					
		erage and it should be					
	charted on the M	•					
		Record). She further					
		ility typically faxes the					
		of the month to inform					
		fusal however the clinical					
	record lacked do						
	record facked do	cumentation.					
	3 The clinical r	record for Resident # 23					
		1/11 at 10:55 A.M.,					
		ses of, but not limited to:					
		, hypertension, and					
	hypothyroidism.						
	   The July 2011	Physician's Orders"					
	The July 2011, "Physician's Orders", indicated, "Accu Checks 4 X						
	· ·						
	L danyNovolog	sliding scale before					

001148

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL 07/22/2	
			B. WIN			0112212	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WOOD F	RIDGE ASSISTED L	IVING		1	GENERATIONS DRIVE I BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	meals and at bed	time141-160=1 units					
	(sic); 161-180=2	units; 181-200=3 units;					
	201-220=4 units;	221-240=5 units;					
	241-260=6 units;	261-280=7 units;					
	281-300=8 units;	301-320=9 units;					
	321-340=10 units	s; 341-360=11 units;					
	361-380=12 units	s; 381-400=13 units;					
	401-420=14 units	s; 421-440=15 units;					
	441-460=16 units	s; 461-480=17 units;					
	481-500=18 units	s; < (less than) 100 or >					
	(greater than) 500	0 call MD"					
	Review of the Ap	oril 2011, "Medication					
	Record", indicate	ed incorrect sliding scale					
	coverage for the	following 7 blood sugars:					
		- 182 given 2 units.					
	Should have rece						
	`	me) - 143 given 0 units.					
	Should have rece						
		I 142 given 0 units.					
	Should have rece						
	`	time) - 143 given 0 units.					
	Should have rece						
		M no Accu Check done					
		I 262 given 6 units.					
	Should have rece						
		M 199 given 2 units.					
	Should have rece	eived 3 units.					
	The Mr. 2011 "	Madiantian Day : :: 111					
	· ·	Medication Record",					
		ct sliding scale coverage					
	for the following	/ Diood sugars:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2RKP11

Facility ID:

001148 If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN			07/22/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WOOD	NDOE ACCIOTED I	IV/INIC		1	GENERATIONS DRIVE		
	RIDGE ASSISTED L	IVING		30016	I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG		given 0 units. Should	-	IAU			DATE
	have received 1 u						
	have received 3 u	given 4 units. Should					
		given 3 units. Should					
	have received 2 u						
		1 211 given 6 units.					
	Should have rece						
		M 128 given 8 units.					
	Should have rece	_					
		I 227 no coverage					
		ould have received 5					
	units.	outu nave received 3					
		given 2 units. Should					
	have received 3 u						
		I 150 given 2 units.					
	Should have rece	•					
		M no Accu Check done					
	3/26/11 11.30 A.	WI HO ACCU CHECK GOHE					
	Review of the Ju	ne 2011, "Medication					
		ed incorrect sliding scale					
		following 6 blood sugars:					
	6/1/11 4:30 P.M.	- 162- no coverage					
		ould have received 2					
	units.						
	6/1/11 HS - 161-	no coverage					
		ould have received 2					
	units.						
	6/6/11 11:30 A.M	1 188 given 2 units.					
	Should have rece	_					
	6/8/11 HS - 189 given 2 units. Should						
	have received 3 i						
	6/13/11 HS - 182	given 2 units. Should					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN	G		07/22/2	011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	GENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING		SOUTH	I BEND, IN46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	<b>.</b>	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	have received 3 units.						
		I 166- no coverage					
		ould have received 2					
	units.						
		M no Accu Check done					
	6/29/11 HS - no <i>i</i>	Accu Check done					
	The July 1st thro	ugh July 20th, 2011,					
	1 -	ord", indicated incorrect					
		erage for the following 3					
	blood sugars:	erage for the following 3					
	blood sugais.						
	7/2/11 HS - 172	given 3 units. Should					
	have received 2 i						
		I 239 given 0 units.					
	Should have rece	•					
		given 3 units. Should					
	have received 2 i	_					
	mave received 2 to	anits.					
	The clinical reco	rd lacked documentation					
	of physician noti						
	F J 222 Will Hotel						
	Interview with L	PN # 1 on 7/21/11 at 2:55					
		ed she was unsure if the					
	l '	d to the physician. She					
		one nurse draws up the					
		*					
	insulin doses and that dose is not checked by a second nurse to confirm accuracy of						
	the dose.						
	die dose.						
	A facility policy titled, "Communication						
	with Physicians", dated 2006, indicated,						
		of this facility to keep					
		vsicians informed					
					!		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE : COMPL		
			A. BUII B. WIN			07/22/2	
NAME OF I	PROVIDER OR SUPPLIEI	<b>II</b> R		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	RIDGE ASSISTED L			1	GENERATIONS DRIVE I BEND, IN46635		
			_		I BEND, IN40033		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	regarding the res	sidents' conditionThe					
	1	maintain written					
		of notification of the					
	1 * *	change in resident					
		resident record"					
		esident #C's clinical					
	1	1 at 12:45 p.m. indicated t not limited to, senile					
	"	d mental status, and HTN					
	(hypertension).	a memai status, and 1111v					
	During a record	review of the "Physician's					
	Orders" dated 4/	01/11 through 4/30/11 the					
	orders for Venla	faxine HCL ER (Effexor)					
	37.5 mg (used fo	or depression) taken once					
	daily by mouth v	was discontinued on					
		order for Venlafaxine HCL					
	1	taken once daily by					
	mouth was starte	ed on 4/7/11.					
	During a record	review of the					
	"	cord" dated 4/8/11 QMA					
		Venlafaxine HCL ER 37.5					
	mg was given.	And again on 4/8/11 LPN					
	1 -	Venlafaxine HCL ER 75					
	mg. Total dose	given on 4/8/11 was					
	Venlafaxine HC	L ER 112.5 mg.					
	During an interes	riew with LPN #1 on					
	"	o.m., she indicated that					
	1 -	e the Venlafaxine HCL ER					
	was given twice on 4/8/11. Also indicated						
	1 -	ust have "accidentally"					
	1	cation Record twice.					

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/22/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  17650 GENERATIONS DRIVE SOUTH BEND, IN46635					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
R0273	notified of the er	nat the physician was ror on 4/8/11.  ation and serving areas in residents ' units) are						
	sanitation and safe including 410 IAC Based on observe record review, the sanitary conditional prevent the potential resource illness or contampractice had the practice of the sanitary conditional resource of the sanitary conditional	ation, interview, and he facility failed to ensure his were maintained to hitial for food borne hination. This deficient hotential to affect 56 of he ate and resided in the	R0273	The apples in the serving bo were discarded and the bow washed. The soup/cereal bo and cookie sheets were re-washed an allowed to air dry.the can opener and stora shelves were cleaned. The drinking glasses were soake remove stains and then reward and allowed to air dry. The shelves in the walk-in cooler be replaced. The refrigerator juice dispenser were cleaned.	I was wls age d to ashed will and			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2RKP11 Facility ID:

001148

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			07/22/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER	· ·		17650 (	GENERATIONS DRIVE		
	RIDGE ASSISTED L	LIVING			I BEND, IN46635		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	· · · · · · · · · · · · · · · · · · ·	from	DATE
	-	ion of the kitchen on			expired items were removed the walk-in cooler.The quate		
	7/20/11 at 11:00				solution was changed. The fa	•	
		the Dietary Supervisor,			is in the process of obtaining		
	the following wa				for a new dish machine with	а	
		ving bowl containing five			built in booster heater.In the	h	
	apples was cover	red with dried water spots			interim, the temperature has increased and a thermomete		
	and a build-up o	f a sticky substance, two			placed in the dish machine d		
	stacks of soup/ce	ereal bowls, 18 juice			the wash and rinse cycle to	3	
	glasses, and thre	e large cookie sheets were			monitor the temperature to		
	stacked and store	ed with water between			ensure adequated sanitizing.		
	them, the cutting	g blade point of the			Registered Dietician will pres an inservice 8/9/11 to review		
	stationary can or	pener had a build-up of			sanitation including proper ha		
		, spice/condiments			washing and glove use, prop		
	_	nad a moderate amount of			food storage, proper p.p.m. i		
	_	cattered on the surface,		quaternary solution, and to cover			
	_	were laden with a		all items noted in this report.The Dining Services Manager will			
		e film rendering them		attend a Serve Safe Training.The			
	_	n anodized finish was			Dining Services Manager or		
		of the walk-in cooler's			designee will review cleaning		
		e inside of one kitchen			schedules daily to ensure the are being followed. The Dinin		
		dried, red drippings on			Services Manager or designe		
	_	e juice dispenser nozzles			will check the quaternary sol		
		f dried, red, sticky			hourly each shift to ensure p	roper	
	substance.	arrou, rou, sorony			p.p.m.The Dining Services  Manager will review the clea	nina	
	Substance.				schedules with the Administr		
	Review of the fa	cility cleaning schedule			weekly on an ongoing basis.		
		ndicated the can opener			The Dining Services Manage		
		•			cooks, Administrator are		
	and shelves were to be cleaned daily. The inside of the ovens were to be cleaned				responsible to monitor to ens compliance.	sure	
	bi-weekly. The juice machine, spice racks				Compilation.		
	and coolers were to be cleaned weekly						
		•					
	and checked for outdated foods. All major						
		to cleaned under weekly.					
	I he July schedu	le indicated all of the					

001148

NAME OF			A. BUILD B. WING		00	COMPLETE 07/22/2011	
WOOD	RIDGE ASSISTED L		B. WING			07/22/2011	
WOOD	RIDGE ASSISTED L						
WOOD	RIDGE ASSISTED L			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		WOOD RIDGE ASSISTED LIVING			GENERATIONS DRIVE		
(X4) ID					BEND, IN46635		
				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE CO	OMPLETION
IAG	+	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DLI ICILIACI)		DATE
		completed through July					
	20, 1011.						
	Several opened f	ood items were expired					
	1	the walk-in cooler					
		day limit: A two liter					
	1 *	ale opened on 5/14/11,					
	1	pened 2/13/11, cottage					
	1 -						
	_	/13/11, and sour cream					
	opened 7/14/11.						
	The quaternary (	quat) solution was tested					
	1 1	apervisor on 7/20/11 at					
	1 '	indicated 50 p.p.m. (parts					
	1	ne Dietary Supervisor					
	1 *	nterview, (at the time) the					
		on was dispensed					
	1 ^	th the water from a					
	1	r indicated the quaternary					
	solution should b	•					
	1	ution was prepared a					
	1	lier, and needed to be					
	_	etary Supervisor was					
	1 *	5 A.M., wiping the stove					
	1	gray towel he retrieved					
		p.p.m. quat bucket.					
	Observation of th	ne automatic dishwasher					
	machine indicate	ed the rinse cycle failed to					
	1	nufacturer's recommended					
	1	sanitation. Three attempts					
	on 7/20/11 at 11:35 A.M., by Dietary Staff						
		theit) recommended to					
	machine indicate get up to the mar temperature for s on 7/20/11 at 11: #20 failed to read	ed the rinse cycle failed to nufacturer's recommended sanitation. Three attempts 35 A.M., by Dietary Staff ch a temperature of 120					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE :		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUII		00	07/22/2	
			B. WIN			0112212	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WOOD F	RIDGE ASSISTED L	IVING			GENERATIONS DRIVE BEND, IN46635		
				L	DEND, INTOUSS		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		the dishware. During	1				21112
		e same process with the					
		pervisor on 7/21/11 at					
		rinse cycle on the					
		nine registered 113					
		ne seconds. He indicated					
	-	vasher used chemical					
		ot hot water sanitation,					
		reach 120 degrees F. and					
		ature for 9 seconds. A					
	1	bel attached to the					
		indicated: "Chemical					
		e: 120 degrees F. for a					
	minimum of nine	_					
		with the Maintenance					
	_	21/11 at 10:30 A.M., he					
	1 1	ald have the repairman					
	out to service the	•					
	out to service the	dishwasher.					
	The Maintenance	e Supervisor, on 7/22/11					
		dicated (as a result of the					
		repairman on the					
		e dishwasher needed a					
	1 *	st with bringing the water					
		the proper sanitation level.					
	_	ated the booster had been					
	ordered to make						
		· r · · ·					
	The Dietary Mar	nager was observed on					
	7/20/11 at 11:15	<del>-</del>					
		s and then entered into					
		er to retrieve hard boiled					
		n observed handling the					
		ne pair of gloves he used					

001148

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL 07/22/2	
			B. WIN			0112212	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WOOD F	RIDGE ASSISTED L	IVING			GENERATIONS DRIVE I BEND, IN46635		
					I BEND, IN40033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
1710		of the cooler. He failed		ino	·		DATE
	^	ntaminated gloves, wash					
		•					
		place the gloves with a					
		handling the hard boiled					
		P.M., on 7/20/11, the					
		was observed wearing					
		s and serving up lunch at					
		He left the table, opened					
	T	nd removed two chef					
		efrigerator. He returned					
	to the steam table						
		on the salads while					
		side of the salad plate,					
	_	a serving tray. He failed					
	to wash his hand	_					
	_	oves prior to touching the					
	1 ^	lad plate. The Dietary					
	_	o observed ladling hot					
	-	p bowls that had the					
		them earlier. The bowls					
	_	ools of water on the					
	bottom of the bo	wl to which he added the					
	soup.						
	~	iew with the Dietary					
	_	/11 at 11:20 A.M., he					
		only been employed at					
	l -	ve weeks. He further					
	indicated the kitc	chen was in need of a					
	deep-cleaning.						
	This state rule su	bstantiates Complaint					
	IN00093337.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY  COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	00	07/22/2011
			B. WING	DDDDGG GITH GT TO GOD	01/22/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
WOOD F	RIDGE ASSISTED L	IVING		GENERATIONS DRIVE I BEND, IN46635	
				1 52115, 11 10000	1
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
R0298	(A) be responsible in 856 IAC 1-7; (B) review the drug practices in the face (C) provide consul procedures of order and disposing of drecord keeping; (D) report, in writing his or her designed dispensing or adm (E) review the drug receiving these sersixty (60) days.  Based on observative record review, the dispose of expired manner. This de 2 of 4 medication	er contract, and shall: If for the duties as specified g handling and storage cility; tation on methods and ering, storing, administering, rugs as well as medication ag, to the administrator or e any irregularities in ainistration of drugs; and g regimen of each resident rvices at least once every ation, interview, and e facility failed to d medications in a timely ficient practice involved as carts and affected 5 of se medications were	R0298	The medications for resident #10, #14, #20, and #30 have been reviewed and corrected either proper labels or destruction. Other residents what the potential to be affect were identified through a fact audit. Items in all medication were inspected to ensure process.	d with  who eed ility carts

001148

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI			
			B. WIN	G		07/22/2	011		
	PROVIDER OR SUPPLIER			17650 (	ADDRESS, CITY, STATE, ZIP CODE GENERATIONS DRIVE I BEND, IN46635	•			
		IVING		300111	BEND, 1140033				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG			DATE		
	Resident: #7, 10, 14, 20, 30 discarding any medications.T technician cor					ne pharmacy			
	Findings include	:			the medication carts on a m basis to ensure compliance.	onthly			
	During inspection	n of the medication carts			consultant pharmacist will				
		20 A.M., accompanied			conduct an in-service for nu				
		following was observed:			and Q.M.A.'s to review prop lableing and disposing of	er			
		iono wing was coserved.			medications in a timely				
	Medication Cart	# 1			manner.The facility has				
	ivical cutton cutt				designated a staff member t	0			
	   Resident # 140	ne Optive eye drops, no			conduct an audit of each medication cart at least wee	lelve			
		nse date 4/15/11; one			using the pharmacy-provide	-			
		s, no open date, dispense			checklist. The desinated sta				
	date 4/5/11	s, no open date, dispense			member will review the findi				
	date 4/3/11				with the Health Services				
	D = 11 = 4 // 10 = 5	Name and manual manua			Supervisor and will correct a	and			
		ne Nasacort nasal spray,			items noted to be deficient. These audits will be conduc	ted on			
	open date 3/22/1	1			an on-going basis.The Heal				
	D = 11 = 4 // 20 = 5				Services Supervisor or design				
		ne Ventolin inhaler, no			will review the information w	rith			
	open date, disper	nse date 9/28/10			the Administrator at least weekly.The Health Services				
	   <b>\</b>	1 11 1 1 1 10			Supervisor, Medical Record				
	1 1	pel on inhaler to identify			Designee, Administrator are				
		entolin inhaler, no open			responsible to monitor to en	sure			
	date				compliance.				
	Medication Cart	# 2							
	Resident # 30o	ne Ventolin inhaler, no							
	open date, disper	nse date 10/5/10							
	Interview on 7/2	1/11 at 10:20 A.M., with							
		icated the inhaler without							
	l '	to Resident # 7. She							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
			B. WIN	G		07/22/2011
NAME OF F	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
				1	GENERATIONS DRIVE	
WOOD R	RIDGE ASSISTED L	IVING		SOUTH	I BEND, IN46635	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	further indicated					
	previously been	discontinued.				
		1/11 . 10 40 4 34 4 79				
		1/11 at 10:40 A.M., LPN				
		pharmacy checks the				
	medication carts	monthly.				
	Review of a "(Na	ame) Expired				
	· ·	imed Orders" sheet,				
		/11 at 11:00 A.M., by				
		ed the last inspection was				
		f the month noted.				
	//2011, 110 day 0	i the month noted.				
	A "Storage and S	Stability (sic) of Selected				
	_	t, dated 02/05, received				
		00 A.M., by LPN # 1,				
		Medicationsneed date				
		other opthamics				
	•	90 daysNasal				
	Sprays/Inhalers	-				
		on90 daysIf no date				
	_	en expiration is from				
	dispensing date	*				
	dispensing date	•				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		07/22/2011
	PROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP CODE GENERATIONS DRIVE H BEND, IN46635	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R0300	Based on observate record review, the properly label me	cer medications, prescription cals used in the facility must rdance with currently conal principles and include cessory and cautionary	R0300	The medications for residen #14, #20, #26, #30 and #48 been reviewed and corrected. Other residents with had the potential to be affect were identified through a fact audit. The pharmacy consult will conduct an inservice 8/1 to review proper labeling of medications. The pharmacy technician audits the medicatrons are properly lab including open date, and or discarded if expired. The fact will designate a staff member audit the medication carts where using the pharmacy-provide checklist. These audits will be conducted on an on-going basis. The designee will revisite findings with the Health Services Supervisor and make corrections necessary. The Health Services Supervisor will revisite findings with the Administ weekly. The Health Services Supervisor, Medical Records Designee, Administrator are resposible to monitor to enscompliance. The Health Services Compliance.	ts #7, have ho ted cility ant 5/11 ation beled dility er to reekly do be siew se any Health riew strator se ure

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE					
AND I LAN OF CORRECTION IDENTIFICATION NOWIBER.		A. BUILDING 07/22/2011					
			B. WIN		A DDDEGG CITY CTATE 7ID CODE	OTTZZTZ	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE GENERATIONS DRIVE		
WOOD R	RIDGE ASSISTED L	IVING			BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	deficient practice						
		s and affected 6 of 55					
		medications were stored					
	in the carts.						
	Resident: #7, 14	4, 20, 26, 30, 48					
	Findings include	:					
	During inspection	n of the medication carts					
		20 A.M., accompanied					
		following was observed:					
		iono wing was costi vai.					
	Medication Cart	# 1					
	Resident # 14or	ne Optive eye drops, no					
	open date label, o	dispense date 4/15/11;					
	_	rops, no open date label,					
	dispense date 4/5	• •					
	_						
	Resident # 20or	ne Ventolin inhaler, no					
	open date label, o	dispense date 9/28/10					
	No pharmacy lab	el on inhaler to identify					
	residentOne Ve	ntolin inhaler, no open					
	date label	-					
	Medication Cart	# 3					
	Resident # 48or	ne Symbicort inhaler, no					
	open date label, o	dispense date 6/6/11					
	Medication Cart	# 2					

		A. BUILDING	00	COMP	(X3) DATE SURVEY COMPLETED		
		B. WING		07/22/2	2011		
NAME OF PROVIDER OR SUPPLIER			GENERATIONS DRIVE	•			
			H BEND, IN40033				
(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE		
0.004 % eye drop	os, no open date label,						
	· ·						
Interview on 7/21/11 at 10:20 A.M., with LPN # 1, she indicated the inhaler without a label belonged to Resident # 7. She further indicated the inhaler had previously been discontinued.  Interview on 7/21/11 at 10:40 A.M., LPN # 1 indicated the pharmacy checks the medication carts monthly.							
Medications & T received on 7/21/LPN # 1, indicate	imed Orders" sheet, '11 at 11:00 A.M., by ed the last inspection was						
Medications" list on 7/21/11 at 11: indicated, "Eye open stickerAll (sic)Expiration Sprays/Inhalers stickerExpiration open is found the	, dated 02/05, received 00 A.M., by LPN # 1, Medicationsneed date other opthamics90 daysNasal need date open on90 daysIf no date n expiration is from						
	IDGE ASSISTED LI  SUMMARY S' (EACH DEFICIENCE REGULATORY OR  Resident # 26 or 0.004 % eye drop dispense date 6/2  Resident # 30 or open date label, of  Interview on 7/21 LPN # 1, she indicated previously been of  Interview on 7/21 # 1 indicated the medication carts  Review of a "(Na Medications & T received on 7/21/ LPN # 1, indicated 7/2011, no day of  A "Storage and S Medications" list on 7/21/11 at 11:0 indicated, "Eye open stickerAll (sic)Expiration Sprays/Inhalers stickerExpiration	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Resident # 26one bottle Travatan Z 0.004 % eye drops, no open date label, dispense date 6/21/11  Resident # 30one Ventolin inhaler, no open date label, dispense date 10/5/10  Interview on 7/21/11 at 10:20 A.M., with LPN # 1, she indicated the inhaler without a label belonged to Resident # 7. She further indicated the inhaler had previously been discontinued.  Interview on 7/21/11 at 10:40 A.M., LPN # 1 indicated the pharmacy checks the	IDGE ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Resident # 26one bottle Travatan Z 0.004 % eye drops, no open date label, dispense date 6/21/11  Resident # 30one Ventolin inhaler, no open date label, dispense date 10/5/10  Interview on 7/21/11 at 10:20 A.M., with LPN # 1, she indicated the inhaler without a label belonged to Resident # 7. She further indicated the inhaler had previously been discontinued.  Interview on 7/21/11 at 10:40 A.M., LPN # 1 indicated the pharmacy checks the medication carts monthly.  Review of a "(Name) Expired Medications & Timed Orders" sheet, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated the last inspection was 7/2011, no day of the month noted.  A "Storage and Stability (sic) of Selected Medications" list, dated 02/05, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated, "Eye Medicationsneed date open stickerAll other opthamics (sic)Expiration90 daysIf no date open is found then expiration is from	IDGE ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Resident # 26—one bottle Travatan Z  0.004 % eye drops, no open date label, dispense date 6/21/11  Resident # 30—one Ventolin inhaler, no open date label, dispense date 10/5/10  Interview on 7/21/11 at 10:20 A.M., with LPN # 1, she indicated the inhaler without a label belonged to Resident # 7. She further indicated the inhaler had previously been discontinued.  Interview on 7/21/11 at 10:40 A.M., LPN # 1 indicated the pharmacy checks the medication carts monthly.  Review of a "(Name) Expired Medications & Timed Orders" sheet, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated the last inspection was 7/2011, no day of the month noted.  A "Storage and Stability (sic) of Selected Medications" list, dated 02/05, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated, "Eye Medicationsneed date open stickerAll other opthamics (sic)Expiration90 daysNasal Sprays/Inhalersneed date open stickerExpiration90 daysIf no date open is found then expiration is from	IDGE ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LES IDENTIFYING INFORMATION)  Resident # 26one bottle Travatan Z  0.004 % eye drops, no open date label, dispense date 6/21/11  Resident # 30one Ventolin inhaler, no open date label, dispense date belonged to Resident # 7. She further indicated the inhaler without a label belonged to Resident # 7. She further indicated the inhaler had previously been discontinued.  Interview on 7/21/11 at 10:40 A.M., LPN  # 1 indicated the pharmacy checks the medication carts monthly.  Review of a "(Name) Expired Medications & Timed Orders" sheet, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated the last inspection was 7/2011, no day of the month noted.  A "Storage and Stability (sic) of Selected Medications" list, dated 02/05, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated, "Eye Medicationsneed date open stickerAll other opthamics (sic)Expiration90 daysNasal Sprays/Inhalersneed date open stickerExpiration90 daysIf no date open is found then expiration is from		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED 07/22/2011			ETED		
NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING			'	17650 GE	DRESS, CITY, STATE, ZIP CODE ENERATIONS DRIVE BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
R0349	on each resident. maintained under employee of the faresponsibility. The (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on intervie facility failed to clinical records via documented appropriate appropria	sible. organized. ew and record review, the ensure the residents' were complete and ropriately for 2 of 7 ed for complete clinical ole of 7.  ecord for Resident # 46 0/11 at 11:00 A.M., ses of, but not limited: , hypertension, and	R034	19	The clinical records for reside #7 and #46 have been review updated and corrected if indicated. Other residents who had the potential to be affects were identified through a faci audit. An inservice will be held 8/15/2011 for all nurses and Q.M.A.'s to review this rule a what is determined to be a complete and accurate media record. The Health Services Supervisor or designee will reports and forms including be not limited to: 24-hour report; medication administration records; insulin and sliding so documentation; daily vital record of each resident. Thes audits will be completed on a continuing basis. The Health Services Supervisor or designed will review the information	ved, o ed lity d on nd cal eview out cale cords ose ical e	08/15/2011

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Event ID:

2RKP11

Facility ID:

001148

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY  COMPLETED  07/22/2011		
NAME OF PROVIDER OR SUPPLIER  WOOD RIDGE ASSISTED LIVING			B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE BENERATIONS DRIVE BEND, IN46635	0172272	•
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSG DEVELOPMENT OF DEFORMATION OF THE PERCENT OF THE PER		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OR Rsliding scale 251-300=6 units; 351-420=10 unit Review of the M Record", indicate only done at 7:30 Review of the Ju Record", indicate only done at 7:30 indicated a omiss testing on 6/22/1 Review of the Ju 2011, "Medicated Accu Checks we A.M. and HS. A "Physician's Te 5/4/11, indicated (before meals)" During interview LPN # 1 indicated blood sugar time physician were n Medication Record blood sugars were meals.  2. Review of Revie	LSC IDENTIFYING INFORMATION) 200-250=4 units;301-350=8 units; s5/4/11"  ay 2011, "Medication ed Accu Checks were 0 A.M. and HS.  ne 2011, "Medication ed Accu Checks were 0 A.M. and HS. It further sion of Accu Check 1 Accu Check at HS.  ly 1st through July 19th, on Record", indicated re only done at 7:30  elephone Orders", dated , "Accu Check A.C.  on 7/21/11 at 2:55 P.M., d she was unsure why the sordered by the of the times on the ord and unsure why the re not done prior to all		TAG	obtained with the Administra least weekly. The Health Ser Supervisor, Medical Records Designee, Administrator are responsible to monitor to enscompliance.	tor at vices	DATE
		45 p.m., indicated not limited to, senile					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	NSTRUCTION  00	(X3) DATE S COMPL 07/22/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹		1	GENERATIONS DRIVE		
WOOD F	RIDGE ASSISTED L	IVING		SOUTH	BEND, IN46635		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		d mental status, and HTN	-	IAG			DATE
	(hypertension).	a mentar status, and 1111					
	Orders" from 12 each stated, "A (milligram) table tablets (650 mg) needed for pain frequency was in						
		Albuterol inhaler 2 puffs					
	· ·	PRN 12/23/10" No					
	` ′	sage was indicated.					
	Orders" from 2/2 stated, "Ventol (microgram) inh mouth as directe	review of the "Physicians 1/11 through 7/20/11 each in HFA 90 mcg aler Inhale 2 puffs by d as needed PRN of frequency was indicated.					
	During a review of the "Medication Record" indicated that Resident # 7						
	ĭ	g of Acetaminophen twice					
	· ·	ce in May, and once in					
	June. The PRN Ventolin had not been administered since Resident # 7 was						
	admitted in Dece						
	_	iew with LPN #1 on o.m., she indicated that all					

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Event ID: 2RKP11 Facility ID: 001148

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING OO COMPLETE					
			B. WING	G		07/22/2	011
NAME OF PROVIDER OR SUPPLIER  WOOD RIDGE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE  17650 GENERATIONS DRIVE  SOUTH BEND, IN46635				
					,		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
		ald have a frequency and		1110			5.112
		cated she was unaware					
	_						
		medications that lacked					
	frequency and do	osage since 12/10/10.					
R0409	(d) Prior to admiss required to have a including history of infectious diseases resident shows no an infectious stage and yearly thereaft.  Based on intervie facility failed to dereceived an annual (Mantoux) after a for 1 of 7 resident testing in a sample.  Resident: # 46  Findings include:  The clinical reconserviewed on 7/20 indicated diagnost diabetes mellitus, hyperthyroidism. Resident # 46 had facility on 4/17/1	sion, each resident shall be health assessment, if significant past or present is and a statement that the evidence of tuberculosis in eas verified upon admission iter.  Ew and record review, the ensure a resident had all tuberculin skin test admitted to the facility its reviewed for Mantoux its reviewed for Mantoux ite of 7.  E. The for Resident # 46 of 11 at 11:00 P.M., is ses of, but not limited:  It further indicated it indicated its deen admitted to the of the o	R0	1409	Other residents who had the potential to be affected were identified through a facility audit. The resident received a mantoux on 7/20/2011. Medic records are audited monthly ensure timely administration yearly mantoux. The medical records checklist includes an area to monitor dates for year mantouxs. The medical records checklist the beginning of ear month and provides a list of residents who are due for year mantouxs. The Health Servi Supervisor or designee administers the mantouxs and results are entered into the medical record. At the end of month, the checklist is review to ensure that all residents requiring a yearly mantoux received one.  The Health Services Supervi	a cal to of a arrly ces ad the the wed	07/22/2011
		ly 2011, Physician's			or designee, Medical Record		
	Orders, indicated	l, "May have yearly			designee are responsible to		
					monitor to ensure compliance	e.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE COMPI 07/22/2	LETED	
NAME OF PROVIDER OR SUPPLIER  WOOD RIDGE ASSISTED LIVING			17650	ADDRESS, CITY, STATE, ZIP CODE GENERATIONS DRIVE I BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
ı	Resident 46's clir received a 1st ste and a 2nd step or record lacked do Mantoux.  During interview on 7/20/11 at 2:5 Resident # 46 ha Tuberculin Test.	LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E RIATE	